
Citation:

Bardgett, RJ and Darling, JC and Webster, E and Kime, N (2015) What makes a good children's doctor? Exploring the child perspective in the OSCE setting. *Medical teacher*, 38 (5). 471 - 475. ISSN 0142-159X DOI: <https://doi.org/10.3109/0142159x.2015.1060301>

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What makes a good children's doctor? Exploring the child perspective in the OSCE setting

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Running Head: Good children's doctor: child perspective in OSCE

Total word count: 3225

Word count (excluding abstract,
acknowledgements, notes on
contributors, declaration of
interest, figure legends and
references): 2599

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Abstract

Background

Patient feedback is increasingly important in clinical practice, and this should include children's views. 28 children aged 8-10 years participating in a large-scale OSCE underwent cranial nerve examination by student candidates. They scored each out of 10 for the question: 'If you had to see a doctor again, how happy would you be to see this one?' An age-adapted qualitative focus group methodology was used to explore why they scored some students more highly than others.

Results

Children's scores for the 256 medical students ranged from 2 to 10 (median 9; mean 8.46). 76% of scores were ≥ 8 . 'Good doctor attributes included: 'friendly', 'funny', 'knowledgeable', 'confident'; 'bad' doctor attributes were: 'making mistakes', 'not paying attention', 'forgot everything', 'serious'. Children's reasons for specific scores are further explored.

Discussion and conclusion

Scores were positively skewed, in line with most patient/simulated patient feedback, and children discriminated between candidates. It should not be assumed that clinician examiners can accurately represent the views of child patients who may value different qualities in doctors. Children participating in our study had clear views of what they want from a doctor: a consultative approach with clear and kind explanation of the process of examination.

(198 words)

Practice points

- Patient feedback can include children's views.
- Children's scores of medical students were positively skewed, in line most patient/simulated patient feedback.
- Children discriminated between candidates.
- Children value a consultative approach with clear and kind explanation of the process of examination.

(39 words)

Background

Traditional medical school consultation skills teaching is largely based on optimising clinical interactions with adult patients or their families. There is much in the literature describing standardised or expert adult patients' perceptions of medical students in the context of both formative and summative assessment (Cleland et al. 2009; Ryan et al. 2010; Park et al. 2011). However, there is little which explores how children perceive encounters with medical students or doctors, and in particular which qualities children value in medical professionals. There has been increasing emphasis on the attributes patients value in their doctors (Schattner et al. 2004). These may differ from what doctors *think* patients consider to be important (Jung et al. 1997). The new revalidation process in the UK puts patient feedback 'at the heart of doctors' professional development' (Anonymous 2012b; Campbell et al. 2012; Rubin 2012). Tools are being developed and used to evaluate paediatric consultations, but are largely based on parent and assessor views (Crossley & Davies 2005; Crossley et al. 2005; Royal College of Paediatrics and Child Health 2014). It is important to take account of children's views regarding their health service provision (Anonymous 2012a). Our work with children in a large-scale OSCE (Darling & Bardgett 2013) provided an opportunity to explore what children consider important in their doctors in the context of a specific simulated consultation.

Aim of the study

The aim of our study was to identify the attributes of a 'good doctor', as described by schoolchildren participating in a summative OSCE as simulated patients.

Methods

In June 2009, 28 children aged 8-10 years participated in a large-scale, 4th year OSCE at Leeds Medical School. All were recruited from a local primary school and underwent cranial nerve examination by approximately 8 or 9 student candidates. For each candidate, the child was asked to score, out of 10, their response to the question: 'If you had to see a doctor again, how happy would you be to see this one?'

A few days after the OSCE, the study investigators visited the primary school to explore the children's perceptions of the day and what attributes they felt denoted a 'good doctor'. A qualitative focus group methodology was used, adapted for age and using interactive games to engage the children. Whilst playing a simple game, the children were asked to shout out, in turn, attributes of a good teacher and subsequently of a good doctor. This strategy was employed to focus the children's attention and help them to understand the purpose of the task, by starting with the more familiar stereotype of a good teacher.

The children were then asked to recall their recent experience of taking part in the OSCE. We explored with the children why they had given candidates low or high scores. In particular, they listed the attributes that they felt characterised high-scoring students. Children were divided into groups, and drew an outline around one of their group on a large sheet of paper. These outlines were designated as representing 'good' or 'bad' doctors and the children drew on and annotated the pictures to signify the important characteristics of the two doctor stereotypes. The pictures were then analysed by the study investigators to generate key themes. Children were asked to give reasons for specific scores.

Results

All 28 children said that they had enjoyed taking part in the exam and agreed that it had been a 'good experience', in line with feedback from children over several years(Darling & Bardgett 2013). Children's scores for the 256 medical students in response to the above question ranged from 2 to 10, with a median of 9 (figure 1) and mean score of 8.46. 76% of medical students were given a score of 8 or above. There were 16 missing values. Scores were positively skewed. The attributes that the children ascribed to 'good' and 'bad' doctors are shown in Box 1. Children's reasons for specific scores are shown in Box 2.

Discussion

The scores given by children were positively skewed, in line with the positive skewing seen in most patient and colleague multisource feedback(Campbell & Wright 2012), and from simulated patients(Homer & Pell 2009). The range of marks awarded indicated that children discriminated between candidates, contrary to the expectations of many of our paediatrician examiners. This raises the question of whether children can contribute a formal mark to candidate's overall score in the same way as adult simulated patients(Homer & Pell 2009). The central point at issue is how much weight to put on the child's views, and whether these measure the same thing as other conventional measures. Crossley et al did not find children's scoring sufficiently reliable to recommend their use in the summative setting(Crossley et al. 2005). However, the Patient Reported Experience Measure advocated by the Royal College of Paediatrics and Child Health (designed to evaluate patient and parent experience of emergency care episodes(Davies 2012)) has a separate validated questionnaire for children 8 years and over.

In the past, the clinicians acting as examiners have assumed that they can accurately represent the views of the patient (or simulated patient) about the candidate's approach in domains such as empathy and respect. However, in adult practice it has been recognised that examiners are not able to accurately represent patient views (McLaughlin et al. 2006), and that it is better to ask patients or simulated patients to give their own scores in these domains. Similarly, in paediatric practice, paediatricians acting as examiners are often asked to give scores on behalf of child patients, but our work suggests that they may be looking at different qualities (Darling & Bardgett 2013). Qualities considered important by paediatric health professionals may be of less value to children themselves, reflecting findings in adult patients (Jung et al. 1997).

The children participating in our study had clear views of what they want from a doctor. In particular, they valued a consultative approach with clear and kind explanation of the process of examination.

At the start of study, we postulated that children's views might be influenced by gender and appearance, but this did not come out as a theme from the focus groups. We found that children did tend to include judgements about clinical performance (once they had met several students) in coming to decisions about whether they would want to see a doctor again.

It would be interesting to explore whether there is a difference between healthy school children and established patients with regard to the qualities that they desire of their doctors.

It may be that children and young adults with chronic conditions, who have a wealth of experience of health professionals, value different attributes or approaches.

We consider that children and young adults could have a role in formative feedback for undergraduates about their approach during consultations, or possibly contribute formally to the marking process. This could be an empowering experience for patients, particularly those with chronic diseases who spend considerable amounts of time in health care settings.

Conclusion

The children participating in the OSCE had clear ideas of what distinguishes a 'good' versus a 'bad' children's doctor. These ideas could inform our teaching and assessment of medical undergraduates in Paediatrics and Child Health, to help make them more child-centred in their approach as future medical practitioners.

Ethical approval

The study was approved by the local medical education research ethics committee.

Acknowledgements

We would like to thank the staff, children and parents of the primary school for their help with our exam. We would also like to thank the Year 4 examination team, who have gone out of their way to ensure a positive experience for all children involved.

Declaration of interest

The authors report no declarations of interest.

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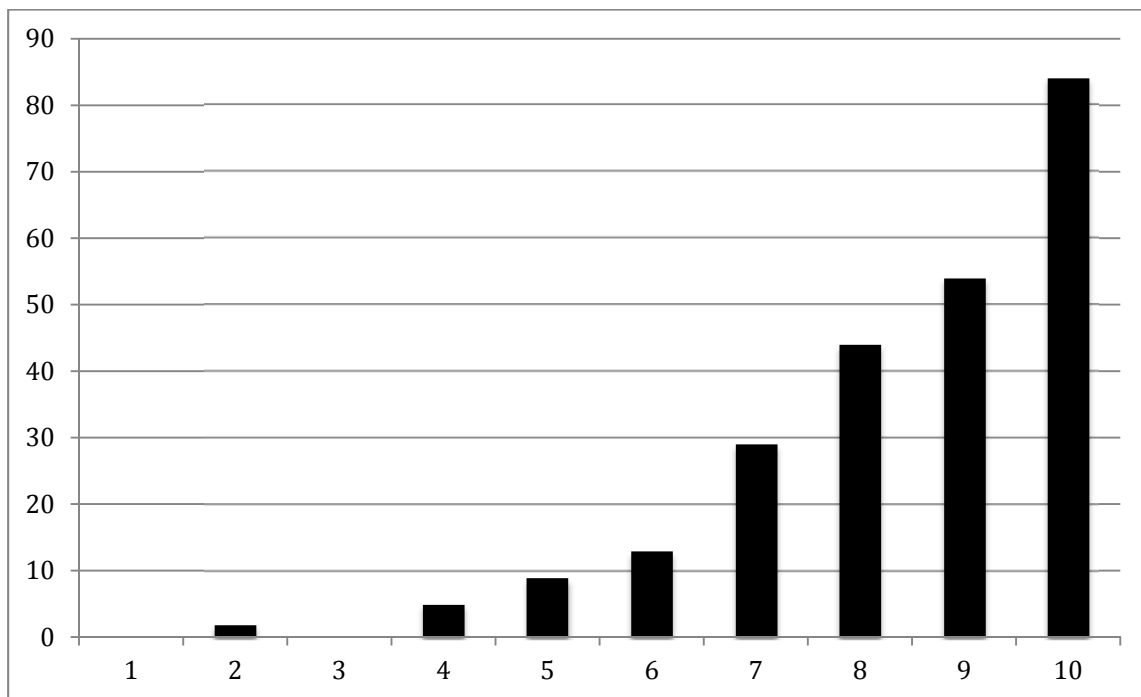
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Figure 1 - Frequency distribution of children's scores



Box 1 - Common attributes identified for ‘good’ and ‘bad’ doctors

Good doctors

- Friendly
- Funny
- Knowledgeable
- Confident

Bad doctors

- Making mistakes
- Not paying attention
- Forgot everything
- Serious

Box 2 – Children’s reasons for scores given

Score of 10

‘Even though they were nervous, they were just doing it right and tried to make me feel comfortable, not frightened or anything’

‘They seriously knew what to do. They were a professor doctor already’

‘He was all friendly and full of smiles and when he made a mistake, he got on with it. That’s good’

Score of 8

‘One girl I gave an 8. She did well but I think she needed to improve on some things. She got some of the names wrong of the things (cranial nerves). She just needed to improve’

Other high scores

‘...checked with me as they went along’

‘...explained things and asked if it was ok’

Low scores

‘One guy kept forgetting what to do’

‘...didn’t explain what they were going to do’

‘...didn’t ask if it was ok to do it’

‘...didn’t tell me his name’